



DEPARTMENT OF THE NAVY  
BUREAU OF MEDICINE AND SURGERY  
2300 E STREET NW  
WASHINGTON DC 20372-5300

Canc: Sep 96  
IN REPLY REFER TO  
BUMEDNOTE 6120  
BUMED-33  
27 Sep 95

BUMED NOTICE 6120

From: Chief, Bureau of Medicine and Surgery  
To: Ships and Stations Having Medical Department Personnel

Subj: REPORT OF MEDICAL ASSESSMENT FORM (DD 2697) AND  
SEPARATION OR RETIREMENT MEDICAL EXAMINATIONS

Ref: (a) ASD(HA) memo of 10 May 95 (NOTAL)

Encl: (1) DD 2697 (Feb 95), Report of Medical Assessment

1. Purpose. To establish guidelines and procedures for using enclosure (1) per reference (a).

2. Scope. Applies to all separation and retirement medical examinations conducted by credentialed health professionals.

a. Introduces a new form that shall be used in addition to the already existing forms currently used for physical examinations.

b. DD 2697 shall be placed in the physical qualifications and exams section of the health record. The form shall be filed behind the Report of Medical History (SF 93).

c. All separating or retiring personnel shall complete this form.

d. The Manual of the Medical Department (MANMED), Chapter 15 shall be updated to include DD 2697.

3. Background. The Report of Medical Assessment (DD 2697) form was developed in response to the Report Language of the House Armed Services for the National Defense Authorization Act for Fiscal Year 1994. The Report Language directed that a comprehensive medical interview be conducted for all separating or retiring service members. The form provides a common instrument to accomplish that goal to provide a record of medical information just before separation or retirement of service members.

4. Procedures. In addition to the standard physical examination procedures already in place, just before separation or retirement from active duty, each service member shall be given a medical interview using the subject form. The interview shall be conducted by a privileged health professional to document any

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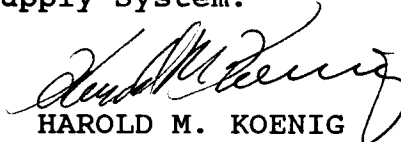
27 Sep 95

complaints or potential service-related (incurred or aggravated) illness or injury. The member must acknowledge, with his or her signature, that the information is complete and truthful.

5. Action. All addressees shall ensure compliance with the requirements in this notice.

6. Form. DD 2697 (2-95), Report of Medical Assessment, S/N 0105-LF-004-4800 can be ordered per NAVSUP P-2002D. Estimated date of supply from the Navy Supply System is November 1995. Local reproduction is authorized in the interim.

7. Cancellation Contingency. Canceled upon revision of MANMED, Chapter 15 and the availability of Report of Medical Assessment form (DD 2697) in the Navy Supply System.

  
HAROLD M. KOENIG

REPORT OF MEDICAL ASSESSMENT				REPORT CONTROL SYMBOL	
<b>PRIVACY ACT STATEMENT</b>					
<b>AUTHORITY:</b> PL 103-160, EO 9397. <b>PRINCIPAL PURPOSE:</b> To be used by the Medical Services to provide a comprehensive medical assessment for active and reserve component service members separating or retiring from active duty. <b>ROUTINE USES:</b> A copy of this form will be released to the Department of Veterans Affairs. <b>DISCLOSURE:</b> Voluntary; however, failure to disclose the requested personal information may result in delay in processing any disability claim.					
<b>SECTION I - TO BE COMPLETED BY SERVICE MEMBER. Any service member who requests a physical examination may have one.</b>					
1. NAME (Last, First, Middle)			2. SOCIAL SECURITY NUMBER		3. RANK
4. COMPONENT		5. UNIT OF ASSIGNMENT			
6a. HOME STREET ADDRESS (Or RFD, including apartment number)		b. CITY	c. STATE	d. ZIP CODE	7. HOME TELEPHONE NUMBER (Include area code)
8. DATE OF LAST PHYSICAL EXAMINATION BY THE MILITARY (YYMMDD)			9. DATE ENTERED ON CURRENT ACTIVE DUTY (YYMMDD)		
10. COMPARED TO MY LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, MY OVERALL HEALTH IS (X one. If "Worse," explain.)					
<input type="checkbox"/> THE SAME <input type="checkbox"/> BETTER <input type="checkbox"/> WORSE					
11. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU HAD ANY ILLNESSES OR INJURIES THAT CAUSED YOU TO MISS DUTY FOR LONGER THAN 3 DAYS? (X one. If "Yes," explain.)					
<input type="checkbox"/> NO <input type="checkbox"/> YES					
12. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU BEEN SEEN BY OR BEEN TREATED BY A HEALTH CARE PROVIDER, ADMITTED TO A HOSPITAL, OR HAD SURGERY? (X one. If "Yes," explain.)					
<input type="checkbox"/> NO <input type="checkbox"/> YES					
13. HAVE YOU SUFFERED FROM ANY INJURY OR ILLNESS WHILE ON ACTIVE DUTY FOR WHICH YOU DID NOT SEEK MEDICAL CARE? (X one. If "Yes," explain.)					
<input type="checkbox"/> NO <input type="checkbox"/> YES					
14. ARE YOU NOW TAKING ANY MEDICATIONS? (X one. If "Yes," list medications.)					
<input type="checkbox"/> NO <input type="checkbox"/> YES					
15. DO YOU HAVE ANY CONDITIONS WHICH CURRENTLY LIMIT YOUR ABILITY TO WORK IN YOUR PRIMARY MILITARY SPECIALTY OR REQUIRE GEOGRAPHIC OR ASSIGNMENT LIMITATIONS? (X one. If "Yes," explain.)					
<input type="checkbox"/> NO <input type="checkbox"/> YES					
16. DO YOU HAVE ANY DENTAL PROBLEMS? (X one. If "Yes," explain.)					
<input type="checkbox"/> NO <input type="checkbox"/> YES					
17. DO YOU HAVE ANY OTHER QUESTIONS OR CONCERN ABOUT YOUR HEALTH? (X one. If "Yes," explain.)					
<input type="checkbox"/> NO <input type="checkbox"/> YES					
18. AT THE PRESENT TIME, DO YOU INTEND TO SEEK DEPARTMENT OF VETERANS AFFAIRS (VA) DISABILITY? (X one. If "Yes," list conditions for which you will ask for VA Disability.)					
<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> UNCERTAIN					
19. CERTIFICATION. I certify that the information provided above is true and complete to the best of my knowledge.					
a. SIGNATURE OF SERVICE MEMBER				b. DATE SIGNED	

**SECTION II - TO BE COMPLETED BY INDIVIDUALLY PRIVILEGED HEALTH CARE PROVIDER**

This Report of Medical Assessment is to be used by the Medical Services to provide a comprehensive medical assessment for active and reserve component service members separating or retiring from active duty. The assessment will cover, as a minimum, the period since the service member's last medical assessment/physical examination, or the period of this call or order to active duty. Any service member who requests a physical examination may have one. Any service member who has indicated "yes" to Item 18 will have an appropriate physical examination, if the last examination is more than 12 months old and/or there are new signs and/or symptoms. If the service member answers "Worse" to Item 10 or "Yes" to Items 11, 12, or 14 through 18, documentation of the injury, illness, or problem should be included in the service member's medical or dental record.

**20. HEALTH CARE PROVIDER COMMENTS** *(All patient complaints must be addressed)***21. WAS PATIENT REFERRED FOR FURTHER EVALUATION?** *(X one. If "Yes," specify where.)*

☐ NO  
☐ YES

**22. PURPOSE OF ASSESSMENT** *(X one. If "Other," explain.)*

☐ **SEPARATION** *(Includes discharge from military service and release from active duty, including release of National Guard and Reserve personnel voluntarily or involuntarily called or ordered to active duty.)*  
☐ **RETIREMENT**  
☐ **OTHER**

**23. MEDICAL FACILITY****24. DATE OF ASSESSMENT**  
(YYMMDD)**25. HEALTH CARE PROVIDER****a. NAME** *(Last, First, Middle Initial)***b. GRADE/RANK****c. SIGNATURE**